February 9, 2001

HOUSE BILL No. 1555

DIGEST OF HB 1555 (Updated February 6, 2001 4:14 PM - DI 97)

Citations Affected: IC 16-21; IC 22-2; IC 25-1; IC 27-1; IC 27-4; IC 27-7; IC 27-8; IC 27-13; IC 34-30; noncode.

Synopsis: Various insurance matters. Requires a hospital and a physician to ensure compliance with the law prohibiting the collection from an enrollee of a sum owed by a health maintenance organization (HMO). Allows a wage assignment for the purpose of paying a premium on a policy of insurance. Includes a HMO and a limited service HMO within the definition of "insurer" for purposes of the law regulating insurance holding company systems. Requires the insurance commissioner to consider the remediation efforts of a person who has engaged in unfair methods of competition or deceptive acts or practices in the business of insurance when assessing fines and penalties. Provides requirements for cancellation or nonrenewal of residential insurance policies. Requires an insurer to notify a residential policyholder regarding coverage for flood damage. Imposes certain requirements when an accident and sickness insurance policy form is no longer actively marketed. Requires a utilization review agent to, under certain circumstances, supply an insured with certain information at the time an adverse utilization review determination is made. Adds requirements for preauthorization of health care services. Requires an insurer to establish and maintain an internal grievance procedure and an external grievance review procedure. Amends the Indiana HMO law concerning: (1) assumption of a corporate name; (2) reinsurance; (3) rights and responsibilities of domestic, foreign, and alien HMOs; (4) annual and other filings; (5) noncovered health care expenditures; (6) receivership; and (7) voluntary dissolution.

Effective: Upon passage; July 1, 2001; January 1, 2002.

Crooks

January 11, 2001, read first time and referred to Committee on Insurance, Corporations and Small Business.
February 8, 2001, amended, reported — Do Pass.

February 9, 2001

First Regular Session 112th General Assembly (2001)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2000 General Assembly.

HOUSE BILL No. 1555

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16-21-2-5, AS AMENDED BY P.L.162-1999, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 5. The governing board of the hospital is the supreme authority in the hospital and is responsible for the following:

(1) The management, operation, and control of the hospital, **including compliance with IC 27-13-15-3.**

(2) The appointment, reappointment, and assignment of privileges to members of the medical staff, with the advice and recommendations of the medical staff, consistent with the individual training, experience, and other qualifications of the medical staff.

(3) Establishing requirements for appointments to and continued service on the hospital's medical staff, consistent with the appointee's individual training, experience, and other qualifications, including the following requirements:

(A) Proof that a medical staff member has qualified as a health care provider under IC 16-18-2-163(a).

(B) The performance of patient care and related duties in a manner that is not disruptive to the delivery of quality medical care in the hospital setting.

(C) Standards of quality medical care that recognize the efficient and effective utilization of hospital resources, developed by the medical staff.

(4) Upon recommendation of the medical staff, establishing protocols within the requirements of this chapter and 410 IAC 5-1.2-1 for the admission, treatment, and care of patients with extended lengths of stay.

SECTION 2. IC 22-2-6-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 2. (a) Any assignment of the wages of an employee is valid only if all of the following conditions are satisfied:

(1) The assignment is:

(A) in writing;

(B) signed by the employee personally;

(C) by its terms revocable at any time by the employee upon written notice to the employer; and

(D) agreed to in writing by the employer.

(2) An executed copy of the assignment is delivered to the employer within ten (10) days after its execution.

(3) The assignment is made for a purpose described in subsection (b).

(b) A wage assignment under this section may be made for the purpose of paying any of the following:

(1) Premium on a policy of insurance. ~~obtained for the employee by the employer.~~

(2) Pledge or contribution of the employee to a charitable or nonprofit organization.

(3) Purchase price of bonds or securities, issued or guaranteed by the United States.

(4) Purchase price of shares of stock, or fractional interests therein, of the employing company, or of a company owning the majority of the issued and outstanding stock of the employing company, whether purchased from such company, in the open market or otherwise. However, if such shares are to be purchased on installments pursuant to a written purchase agreement, the employee has the right under the purchase agreement at any time before completing purchase of such shares to cancel said agreement and to have repaid promptly the amount of all installment payments which theretofore have been made.

(5) Dues to become owing by the employee to a labor organization of which the employee is a member.

(6) Purchase price of merchandise sold by the employer to the employee, at the written request of the employee.

(7) Amount of a loan made to the employee by the employer and evidenced by a written instrument executed by the employee.

(8) Contributions, assessments, or dues of the employee to a hospital service or a surgical or medical expense plan or to an employees' association, trust, or plan existing for the purpose of paying pensions or other benefits to said employee or to others designated by the employee.

(9) Payment to any credit union, nonprofit organizations, or associations of employees of such employer organized under any law of this state or of the United States.

(10) Payment to any person or organization regulated under the Uniform Consumer Credit Code (IC 24-4.5) for deposit or credit to the employee's account by electronic transfer or as otherwise designated by the employee.

(11) Premiums on policies of insurance and annuities purchased by the employee on the employee's life.

(12) The purchase price of shares or fractional interest in shares in one (1) or more mutual funds.

SECTION 3. IC 25-1-9-4, AS AMENDED BY P.L.22-1999, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 4. (a) A practitioner shall conduct the practitioner's practice in accordance with the standards established by the board regulating the profession in question and is subject to the exercise of the disciplinary sanctions under section 9 of this chapter if, after a hearing, the board finds:

(1) a practitioner has:

(A) engaged in or knowingly cooperated in fraud or material deception in order to obtain a license to practice;

(B) engaged in fraud or material deception in the course of professional services or activities; or

(C) advertised services in a false or misleading manner;

(2) a practitioner has been convicted of a crime that has a direct bearing on the practitioner's ability to continue to practice competently;

(3) a practitioner has knowingly violated any state statute or rule, or federal statute or regulation, regulating the profession in question;

(4) a practitioner has continued to practice although the

practitioner has become unfit to practice due to:

(A) professional incompetence that:

(i) may include the undertaking of professional activities that the practitioner is not qualified by training or experience to undertake; and

(ii) does not include activities performed under IC 16-21-2-9;

(B) failure to keep abreast of current professional theory or practice;

(C) physical or mental disability; or

(D) addiction to, abuse of, or severe dependency upon alcohol or other drugs that endanger the public by impairing a practitioner's ability to practice safely;

(5) a practitioner has engaged in a course of lewd or immoral conduct in connection with the delivery of services to the public;

(6) a practitioner has allowed the practitioner's name or a license issued under this chapter to be used in connection with an individual who renders services beyond the scope of that individual's training, experience, or competence;

(7) a practitioner has had disciplinary action taken against the practitioner or the practitioner's license to practice in any other state or jurisdiction on grounds similar to those under this chapter;

(8) a practitioner has diverted:

(A) a legend drug (as defined in IC 16-18-2-199); or

(B) any other drug or device issued under a drug order (as defined in IC 16-42-19-3) for another person;

(9) a practitioner, except as otherwise provided by law, has knowingly prescribed, sold, or administered any drug classified as a narcotic, addicting, or dangerous drug to a habitue or addict; ~~or~~

(10) a practitioner has failed to comply with an order imposing a sanction under section 9 of this chapter; **or**

(11) a practitioner who is a participating provider of a health maintenance organization has knowingly collected or attempted to collect from a subscriber or enrollee of the health maintenance organization any sums that are owed by the health maintenance organization.

(b) A certified copy of the record of disciplinary action is conclusive evidence of the other jurisdiction's disciplinary action under subsection (a)(7).

SECTION 4. IC 27-1-23-1 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 1. As used in this chapter, the following terms shall have the respective meanings set forth in this section, unless the context shall otherwise require:

(a) An "acquiring party" is the specific person by whom an acquisition of control of a domestic insurer or of any corporation controlling a domestic insurer is to be effected, and each person who directly, or indirectly through one (1) or more intermediaries, controls the person specified.

(b) An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one (1) or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(c) A "beneficial owner" of a voting security includes any person who, directly or indirectly, through any contract, arrangement, understanding, relationship, revocable or irrevocable proxy, or otherwise has or shares:

(1) voting power including the power to vote, or to direct the voting of, the security; or

(2) investment power which includes the power to dispose, or to direct the disposition, of the security.

(d) "Commissioner" means the insurance commissioner of this state.

(e) "Control" (including the terms "controlling", "controlled by", and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the beneficial ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office. Control shall be presumed to exist if any person beneficially owns ten percent (10%) or more of the voting securities of any other person. The commissioner may determine this presumption has been rebutted only by a showing made in the manner provided by section 3(k) of this chapter that control does not exist in fact, after giving all interested persons notice and an opportunity to be heard. Control shall be presumed again to exist upon the acquisition of beneficial ownership of each additional five percent (5%) or more of the voting securities of the other person. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(f) "Department" means the department of insurance created by IC 27-1-1-1.

(g) A "domestic insurer" is an insurer organized under the laws of

this state.

(h) "Earned surplus" means an amount equal to the unassigned funds of an insurer as set forth in the most recent annual statement of an insurer that is submitted to the commissioner, excluding surplus arising from unrealized capital gains or revaluation of assets.

(i) An "insurance holding company system" consists of two (2) or more affiliated persons, one (1) or more of which is an insurer.

(j) "Insurer" has the same meaning as set forth in IC 27-1-2-3, except that it does not include:

(1) agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(2) fraternal benefit societies; or

(3) nonprofit medical and hospital service associations.

The term includes a health maintenance organization (as defined in IC 27-13-1-19) and a limited service health maintenance organization (as defined in IC 27-13-1-27).

(k) A "person" is an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any securities broker performing no more than the usual and customary broker's function.

(l) A "policyholder" of a domestic insurer includes any person who owns an insurance policy or annuity contract issued by the domestic insurer, any person reinsured by the domestic insurer under a reinsurance contract or treaty between the person and the domestic insurer, and any health maintenance organization with which the domestic insurer has contracted to provide services or protection against the cost of care.

(m) A "subsidiary" of a specified person is an affiliate controlled by that person directly or indirectly through one or more intermediaries.

(n) "Surplus" means the total of gross paid in and contributed surplus, special surplus funds, and unassigned surplus, less treasury stock at cost.

(o) "Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

SECTION 5. IC 27-4-1-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to

be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Making or permitting any of the following:

(A) Unfair discrimination between individuals of the same class and equal expectation of life in the rates or assessments charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract; however, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(B) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever; however, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:

(i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;

(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or

(iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, limited liability company, or partnership, or any dividends, savings, or profits accrued thereon, or anything of value whatsoever not specified in the contract. Nothing in this subdivision and subdivision (7) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, so long as any such bonuses or

abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders.

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such policy year.

(D) Paying by an insurer or agent thereof duly licensed as such under the laws of this state of money, commission, or brokerage, or giving or allowing by an insurer or such licensed agent thereof anything of value, for or on account of the solicitation or negotiation of policies or other contracts of any kind or kinds, to a broker, agent, or solicitor duly licensed under the laws of this state, but such broker, agent, or solicitor receiving such consideration shall not pay, give, or allow credit for such consideration as received in whole or in part, directly or indirectly, to the insured by way of rebate.

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular insurance agent or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of its or his right to approve or disapprove of the insurance company selected by the borrower to underwrite the insurance.

(10) Entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance.

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of agents or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10).

The enumeration in this chapter of specific unfair methods of

competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.

(12) Requiring as a condition precedent to the sale of real or personal property under any contract of sale, conditional sales contract, or other similar instrument or upon the security of a chattel mortgage, that the buyer of such property negotiate any policy of insurance covering such property through a particular insurance company, agent, or broker or brokers. However, this subdivision shall not prevent the exercise by any seller of such property or the one making a loan thereon, of his, her, or its right to approve or disapprove of the insurance company selected by the buyer to underwrite the insurance.

(13) Issuing, offering, or participating in a plan to issue or offer, any policy or certificate of insurance of any kind or character as an inducement to the purchase of any property, real, personal, or mixed, or services of any kind, where a charge to the insured is not made for and on account of such policy or certificate of insurance. However, this subdivision shall not apply to any of the following:

(A) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in such credit unions.

(B) Insurance employed as a means of guaranteeing the performance of goods and designed to benefit the purchasers or users of such goods.

(C) Title insurance.

(D) Insurance written in connection with an indebtedness and intended as a means of repaying such indebtedness in the event of the death or disability of the insured.

(E) Insurance provided by or through motorists service clubs or associations.

(F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:

(i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;

(ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the state department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25 or IC 27-1-22-26 concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-1-15.5-3(h).

(23) Violating IC 27-8-26 concerning genetic screening or testing.

(24) Violating IC 27-8-17.5 concerning preauthorization.

SECTION 6. IC 27-4-1-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) If after a hearing under IC 4-21.5-3, the commissioner determines that the method of competition or the act or practice in question is defined in section 4 of this chapter and that the person complained of has engaged in such method of competition, act, or practice in violation of this chapter, he shall reduce his findings to writing and shall issue and cause to be served on the person charged with the violation an order requiring such person to cease and desist from such method of competition, act, or

practice, and the commissioner may at his discretion order one (1) or more of the following:

(1) Payment of a civil penalty of not more than twenty-five thousand dollars ($25,000) for each act or violation. ~~but. not to exceed an aggregate penalty of one hundred thousand dollars ($100,000) in any twelve (12) month period unless~~ **If** the person knew or reasonably should have known that he was in violation of this chapter, ~~in which case~~ the penalty may be not more than fifty thousand dollars ($50,000) for each act or violation ~~but not to exceed an. aggregate penalty of two hundred thousand dollars ($200,000) in any twelve (12) month period.~~

(2) Suspension or revocation of the person's license, or certificate of authority, if he knew or reasonably should have known he was in violation of this chapter.

(b) **In determining the amount of a civil penalty under subsection (a)(1), the commissioner shall consider the remediation efforts undertaken by the person.**

(c) All civil penalties imposed and collected under this section shall be deposited in the state general fund.

SECTION 7. IC 27-7-12 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]:

Chapter 12. Termination of Residential Policies

Sec. 1. (a) This chapter applies to policies of insurance covering risks to property located in Indiana that take effect or are renewed after June 30, 2001, and that insure loss of or damage to:

(1) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(2) personal property:

(A) in which the named insured has an insurable interest; and

(B) that is used within a residential dwelling for personal, family, or household purposes.

(b) This chapter does not apply to the following:

(1) A policy of inland marine insurance.

(2) The cancellation or nonrenewal of an automobile insurance policy under IC 27-7-6.

(3) The cancellation or nonrenewal of a commercial property and casualty insurance policy under IC 27-1-31-2.5.

Sec. 2. (a) As used in this chapter, "cancellation" or "cancelled" refers to a termination of property insurance coverage that occurs

during the policy term.

(b) As used in this chapter, "nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on policies of insurance subject to this chapter, regardless of whether the payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. The term includes the failure to pay dues or fees where payment of the dues or fees is a prerequisite to obtaining or continuing property insurance coverage.

(c) As used in this chapter, "nonrenewal" or "nonrenewed" refers to a termination of property insurance coverage that occurs at the end of the policy term.

(d) As used in this chapter, "renewal" or "to renew" refers to:

(1) the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer; or

(2) the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term.

(e) As used in this chapter, "termination" means a cancellation or nonrenewal. The term does not include:

(1) the requirement of a reasonable deductible;

(2) reasonable changes in the amount of insurance; or

(3) reasonable reductions in policy limits or coverage;

if the requirements or changes are directly related to the hazard involved and are made on the renewal date for the policy.

Sec. 3. (a) Notice of cancellation of property insurance coverage by an insurer must:

(1) be in writing;

(2) be delivered or mailed to the named insured at the last known address of the named insured;

(3) state the effective date of the cancellation; and

(4) upon request of the named insured, be accompanied by a written explanation of the specific reasons for the cancellation.

(b) An insurer shall provide written notice of cancellation to the named insured at least:

(1) ten (10) days before canceling a policy, if the cancellation is for nonpayment of a premium;

(2) twenty (20) days before canceling a policy, if the cancellation occurs more than sixty (60) days after the date of

issuance of the policy; and

(3) ten (10) days before canceling a policy, if the cancellation occurs not more than sixty (60) days after the date of issuance of the policy.

(c) If the policy was procured by an independent agent licensed in Indiana, the insurer shall deliver or mail notice of cancellation to the agent not less than ten (10) days before the insurer delivers or mails the notice to the named insured, unless the obligation to notify the agent is waived in writing by the agent.

Sec. 4. (a) Notice of nonrenewal by an insurer must:

(1) be in writing;

(2) be delivered or mailed to the named insured at the last known address of the named insured;

(3) state the insurer's intention not to renew the policy upon expiration of the current policy period;

(4) upon request of the named insured, be accompanied by a written explanation of the specific reasons for the nonrenewal; and

(5) be provided to the named insured at least twenty (20) days before the expiration of the current policy period.

(b) If the policy was procured by an independent agent licensed in Indiana, the insurer shall deliver or mail notice of nonrenewal to the agent not less than ten (10) days before the insurer delivers or mails the notice to the named insured, unless the obligation to notify the agent is waived in writing by the agent.

(c) If an insurer mails or delivers to an insured a renewal notice, bill, certificate, or policy indicating the insurer's willingness to renew a policy and the insured does not respond, the insurer is not required to provide to the insured notice of intention not to renew.

Sec. 5. (a) A written explanation provided under section 3 or 4 of this chapter must be of sufficient clarity and specificity to enable a reasonable lay person to identify the basis for the insurer's decision without further inquiry.

(b) If notice is not provided under section 4 of this chapter, coverage is considered to be renewed only for the ensuing policy period upon payment of the appropriate premiums under the same terms and conditions, and subject to section 6 of this chapter, unless the named insured has accepted replacement coverage with another insurer or unless the named insured has agreed to the nonrenewal.

Sec. 6. After coverage has been in effect for more than sixty (60) days or after the effective date of a renewal policy, a notice of

cancellation shall not be issued unless cancellation is based on at least one (1) of the following:

(1) Nonpayment of a premium.

(2) Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

(3) Discovery of willful or reckless acts or omissions on the part of the named insured that increase a hazard insured against.

(4) The occurrence of a change in the risk that substantially increases a hazard insured against after insurance coverage has been issued or renewed.

(5) A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to an insured property or the occupancy of the property that substantially increases any hazard insured against.

(6) A determination by the insurance commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of Indiana.

(7) Real property taxes owing on the insured property have been delinquent for two (2) or more years and continue to be delinquent at the time notice of cancellation is issued.

Sec. 7. Termination of property insurance coverage by an insurer is prohibited if the termination is based on any of the following:

(1) Upon the race, religion, nationality, ethnic group, age, sex, or marital status of the applicant or named insured.

(2) Solely upon the lawful occupation or profession of the applicant or named insured. However, this subdivision does not apply to an insurer that limits its market to one (1) lawful occupation or profession or to several related lawful occupations or professions.

(3) Upon the age or location of the residence of the applicant or named insured, unless that decision is for a business purpose that is not a mere pretext for a decision based on factors prohibited in this chapter or any other provision of this title.

(4) Upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

(5) Upon the fact that the applicant or named insured

previously obtained insurance coverage through a residual market insurance mechanism.

Sec. 8. The named insured must be given notice of a transfer of a policy, including a transfer between insurers within the same insurance group. The notice must:

(1) be in writing;

(2) be delivered or mailed to the named insured at the last known address of the named insured;

(3) be provided to the named insured at least twenty (20) days before the transfer; and

(4) identify the insurer to which the policy will be transferred.

Sec. 9. (a) The following persons are immune from civil liability for any communication giving notice of or specifying the reasons for a termination or for any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for a termination under this chapter:

(1) Employees of the department of insurance.

(2) An insurer or its authorized representative, agent, or employee.

(3) A licensed insurance agent.

(4) A person furnishing information to an insurer as to reasons for a termination.

(b) This section does not apply to statements made in bad faith with malice in fact.

SECTION 8. IC 27-7-13 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2002]:

Chapter 13. Required Notice of Flood Coverage in a Residential Policy

Sec. 1. (a) This chapter applies to policies of insurance covering risks to property located in Indiana that are issued or renewed after December 31, 2001, and that insure against loss of or damage to:

(1) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(2) personal property:

(A) in which the named insured has an insurable interest; and

(B) that is used within a residential dwelling for personal, family, or household purposes.

(b) This chapter does not apply to the following:

(1) A policy of inland marine insurance.

(2) An automobile insurance policy under IC 27-7-6.

(3) A commercial property and casualty insurance policy under IC 27-1-31.

Sec. 2. If a policy of insurance described in section 1 of this chapter does not provide coverage for flood damage:

(1) the policy jacket must contain a prominently printed notice stating; or

(2) the policyholder must be given written notice when the policy is issued, or upon the first renewal after December 31, 2001;

that coverage for flood damage may be available through the National Flood Insurance Program.

SECTION 9. IC 27-8-5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 1. (a) The term "policy of accident and sickness insurance", as used in this chapter, includes any policy or contract covering one (1) or more of the kinds of insurance described in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the individual basis under this section and sections 2 through 9 of this chapter, on the group basis under this section and sections 16 through 19 of this chapter, on the franchise basis under this section and section 11 of this chapter, or on a blanket basis under section 15 of this chapter and (except as otherwise expressly provided in this chapter) shall be exclusively governed by this chapter.

(b) No policy of accident and sickness insurance may be issued or delivered to any person in this state, nor may any application, rider, or endorsement be used in connection with an accident and sickness insurance policy until a copy of the form of the policy and of the classification of risks and the premium rates, or, in the case of assessment companies, the estimated cost pertaining thereto, have been filed with the commissioner. This section is applicable also to assessment companies and fraternal benefit associations or societies.

(c) No policy of accident and sickness insurance may be issued, nor may any application, rider, or endorsement be used in connection with a policy of accident and sickness insurance, until the expiration of thirty (30) days after it has been filed under subsection (b), unless the commissioner gives his written approval to it before the expiration of the thirty (30) day period.

(d) The commissioner may, within thirty (30) days after the filing of any form under subsection (b), disapprove the form:

(1) if, in the case of an individual accident and sickness form, the benefits provided therein are unreasonable in relation to the

premium charged; or

(2) if, in the case of an individual, blanket, or group accident and sickness form, it contains a provision or provisions that are unjust, unfair, inequitable, misleading, or deceptive or that encourage misrepresentation of the policy.

(e) If the commissioner notifies the insurer that filed a form that the form does not comply with this section, it is unlawful thereafter for the insurer to issue the form or use it in connection with any policy. In the notice given under this subsection, the commissioner shall specify the reasons for his disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer.

(f) The commissioner may at any time, after a hearing of which not less than twenty (20) days written notice has been given to the insurer, withdraw his approval of any form filed under subsection (b) on any of the grounds stated in this section. It is unlawful for the insurer to issue the form or use it in connection with any policy after the effective date of the withdrawal of approval. The notice of any hearing called under this subsection must specify the matters to be considered at the hearing, and any decision affirming disapproval or directing withdrawal of approval under this section must be in writing and must specify the reasons for the decision.

(g) Any order or decision of the commissioner under this section is subject to review under IC 4-21.5.

(h) If an individual policy of accident and sickness insurance form is no longer actively marketed, a filing to increase a premium rate on the form must include:

(1) a statement indicating whether a similar individual policy form is actively marketed; and

(2) a comparison of the original policy to the similar form that is actively marketed, if any, including a comparison of benefits, services, terms, and premium rates.

The commissioner may disapprove a premium rate increase if the requested rate for the form that is no longer actively marketed significantly exceeds rates for actively marketed individual policy forms that provide similar benefits.

SECTION 10. IC 27-8-5-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 1.5. If:**

(1) a policy of accident and sickness insurance form is no longer actively marketed by an insurer; and

(2) not more than two hundred (200) claims are filed nationally in a twelve (12) month period for a block of

business in force under the form;

the insurer shall, for rating and monitoring purposes, combine individual policies in force under the form with other blocks of business of the same type that offer similar benefits and rates.

SECTION 11. IC 27-8-17-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 12. (a) A utilization review agent shall make available ~~upon request~~ **to an enrollee at the time an adverse utilization review determination is made:**

(1) a written description of the appeals procedure by which an enrollee or a provider of record may ~~obtain a review of a~~ **appeal the** utilization review determination by the utilization review agent; **and**

(2) in the case of an enrollee covered under an accident and sickness policy or a health maintenance organization contract described in subsection (d), notice that the enrollee has the right to appeal the utilization review determination under IC 27-8-28 or IC 27-13-10 and the toll free telephone number that the enrollee may call to request a review of the determination or obtain further information about the right to appeal.

(b) The appeals procedure provided by a utilization review agent must meet the following requirements:

(1) On appeal, the determination not to certify an admission, a service, or a procedure as necessary or appropriate must be made by a health care provider licensed in the same discipline as the provider of record.

(2) The determination of the appeal of a utilization review determination not to certify an admission, service, or procedure must be completed within thirty (30) days after:

(A) the appeal is filed; and

(B) all information necessary to complete the appeal is received.

(c) A utilization review agent shall provide an expedited appeals process for emergency or life threatening situations. The determination of an expedited appeal under the process required by this subsection shall be made by a physician and completed within forty-eight (48) hours after:

(1) the appeal is initiated; and

(2) all information necessary to complete the appeal is received by the utilization review agent.

(d) If an enrollee is covered under an accident and sickness insurance policy (as defined in IC 27-8-28-1) or a contract issued

by a health maintenance organization (as defined in IC 27-13-1-19), the enrollee's exclusive right to appeal a utilization review determination is provided under IC 27-8-28 or IC 27-13-10, respectively.

(e) A utilization review agent shall make available upon request a written description of the appeals procedure that an enrollee or provider of record may use to obtain a review of a utilization review determination by the utilization review agent.

SECTION 12. IC 27-8-17.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 17.5. Preauthorization

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health insurance plan.

Sec. 2. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1.

Sec. 3. As used in this chapter, "health insurance plan" means coverage provided under any of the following:

(1) A hospital or medical expense incurred policy or certificate.

(2) A health maintenance organization subscriber contract.

(3) An employer based health insurance arrangement.

(4) An individual health insurance policy.

(5) A policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(6) An employee welfare benefit plan (as defined in 29 U.S.C. 1002) that is self-funded.

(7) A conversion policy issued under IC 27-8-15-31 or IC 27-8-15-31.1.

Sec. 4. As used in this chapter, "insurer" means any person that provides coverage for health care services in Indiana. The term includes the following:

(1) An insurance company authorized to do business in Indiana.

(2) A health maintenance organization (as defined in IC 27-13-1-19) or limited service health maintenance organization (as defined in IC 27-13-1-27).

(3) A state employee health benefit plan established under IC 5-10-8-7.

(4) Any other person that provides coverage for health care services through a health insurance plan regulated under

IC 27.

Sec. 5. An insurer shall issue a confirmation number to a covered individual when the insurer authorizes the provision of health care services:

(1) directly;

(2) through a participating provider; or

(3) through any other authorized representative of the insurer.

Sec. 6. If an insurer or an insurer's authorized representative authorizes the provision of health care services, the insurer shall not retract the authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on such authorization, unless:

(1) the authorization was based on a material misrepresentation or omission regarding the covered individual's health condition or cause of the health condition;

(2) the health insurance plan terminates before the health care services are provided; or

(3) the covered individual's coverage under the health insurance plan terminates before the health care services are provided.

Sec. 7. If a dispute arises between an insurer and the provider of an authorized health care service concerning whether the health care service was provided in the manner or type authorized by the insurer, the insurer shall hold the covered individual harmless from any claims made by the provider concerning the service. Failure to hold the covered individual harmless under this section is a violation of IC 27-4-1-4. This section does not apply to any copayment, coinsurance, or deductible payable by a covered individual under the health insurance plan.

SECTION 13. IC 27-8-28 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 28. Internal Grievance Procedures

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the kinds of insurance described in Class 1(b) and 2(a) of IC 27-1-5-1.

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy issued as an individual policy.

(5) A limited benefit health insurance policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

Sec. 2. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

Sec. 3. As used in this chapter, "covered individual" means an individual who is covered under an accident and sickness insurance policy.

Sec. 4. As used in this chapter, "department" refers to the department of insurance.

Sec. 5. As used in this chapter, "external grievance" means the independent review under IC 27-8-29 of a grievance filed under this chapter.

Sec. 6. As used in this chapter, "grievance" means any dissatisfaction expressed by or on behalf of a covered individual regarding:

(1) the appropriateness or medical necessity of health care services;

(2) a determination that a proposed service is experimental or investigational;

(3) the availability of participating providers;

(4) the handling or payment of claims for health care services; or

(5) matters pertaining to the contractual relationship between:

(A) a covered individual and an insurer; or

(B) a group policyholder and an insurer;

and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

Sec. 7. As used in this chapter, "grievance procedure" means a written procedure established and maintained by an insurer for filing, investigating, and resolving grievances and appeals.

Sec. 8. As used in this chapter, "insured" means:

(1) an individual whose employment status or other status except family dependency is the basis for coverage under a group accident and sickness insurance policy; or

(2) in the case of an individual accident and sickness insurance policy, the individual in whose name the policy is issued.

Sec. 9. As used in this chapter, "insurer" means any person who delivers or issues for delivery an accident and sickness insurance policy or certificate in Indiana.

Sec. 10. An insurer shall establish and maintain a grievance procedure that complies with the requirements of this chapter for the resolution of grievances initiated by a covered individual.

Sec. 11. The commissioner may examine the grievance procedure of any insurer.

Sec. 12. An insurer shall maintain all grievance records received by the insurer after the most recent examination of the insurer's grievance procedure by the commissioner.

Sec. 13. (a) An insurer shall provide timely, adequate, and appropriate notice to each insured of:

(1) the grievance procedure required under this chapter;

(2) the external grievance procedure required under IC 27-8-29;

(3) information on how to file:

(A) a grievance under this chapter; and

(B) a request for an external grievance review under IC 27-8-29; and

(4) a toll free telephone number through which a covered individual may contact the insurer at no cost to the covered individual to obtain information and to file grievances.

(b) An insurer shall prominently display on all notices to covered individuals the toll free telephone number and the address at which a grievance or request for external grievance review may be filed.

Sec. 14. (a) A covered individual may file a grievance orally or in writing.

(b) An insurer shall make available to covered individuals a toll free telephone number through which a grievance may be filed. The toll free telephone number must:

(1) be staffed by a qualified representative of the insurer;

(2) be available for at least forty (40) hours per week during normal business hours; and

(3) accept grievances in the languages of the major population groups served by the insurer.

(c) A grievance is considered to be filed on the first date it is received, either by telephone or in writing.

Sec. 15. (a) An insurer shall establish procedures to assist covered individuals in filing grievances.

(b) A covered individual may designate a representative to file a grievance for the covered individual and to represent the covered individual in a grievance under this chapter.

Sec. 16. (a) An insurer shall establish written policies and procedures for the timely resolution of grievances filed under this chapter. The policies and procedures must include the following:

(1) An acknowledgment of the grievance, oral or in writing, to the covered individual within three (3) business days after receipt of the grievance.

(2) Documentation of the substance of the grievance and any actions taken.

(3) An investigation of the substance of the grievance, including any aspects involving clinical care.

(4) Notification to the covered individual of the disposition of the grievance and the right to appeal.

(5) Standards for timeliness in:

(A) responding to grievances; and

(B) providing notice to covered individuals of:

(i) the disposition of the grievance; and

(ii) the right to appeal;

that accommodate the clinical urgency of the situation.

(b) An insurer shall appoint at least one (1) individual to resolve a grievance.

(c) A grievance must be resolved as expeditiously as possible, but not more than twenty (20) business days after the grievance is filed. If an insurer is unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond the insurer's control, the insurer shall:

(1) before the twentieth business day, notify the covered individual in writing of the reason for the delay; and

(2) issue a written decision regarding the grievance within an additional ten (10) business days.

(d) An insurer shall notify a covered individual in writing of the resolution of a grievance within five (5) business days after completing an investigation. The grievance resolution notice must include the following:

(1) A statement of the decision reached by the insurer.

(2) A statement of the reasons, policies, and procedures that

are the basis of the decision.

(3) Notice of the covered individual's right to appeal the decision.

(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Sec. 17. (a) An insurer shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

(1) Written or oral acknowledgment of the appeal not more than three (3) business days after the appeal is filed.

(2) Documentation of the substance of the appeal and the actions taken.

(3) Investigation of the substance of the appeal, including any aspects of clinical care involved.

(4) Notification to the covered individual:

(A) of the disposition of an appeal; and

(B) that the covered individual may have the right to further remedies allowed by law.

(5) Standards for timeliness in:

(A) responding to an appeal; and

(B) providing notice to covered individuals of:

(i) the disposition of an appeal; and

(ii) the right to initiate an external grievance review under IC 27-8-29;

that accommodate the clinical urgency of the situation.

(b) In the case of an appeal of a grievance decision described in section 6(1) or 6(2) of this chapter, an insurer shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel must include one (1) or more individuals who:

(1) have knowledge in the medical condition, procedure, or treatment at issue;

(2) are licensed in the same profession as the provider who proposed, denied, or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and

(4) do not have a direct business relationship with the covered individual or the health care provider who previously

recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved:

(1) as expeditiously as possible, reflecting the clinical urgency of the situation; and

(2) in any case, not later than forty-five (45) days after the appeal is filed.

(d) An insurer shall allow a covered individual the opportunity to:

(1) appear in person before; or

(2) if unable to appear in person, otherwise appropriately communicate with;

the panel appointed under subsection (b).

(e) An insurer shall notify a covered individual in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing the investigation. The appeal resolution notice must include the following:

(1) A statement of the decision reached by the insurer.

(2) A statement of the reasons, policies, and procedures that are the basis of the decision.

(3) Notice of the covered individual's right to further remedies allowed by law, including the right to external grievance review by an independent review organization under IC 27-8-29.

(4) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

Sec. 18. An insurer may not take action against a provider solely on the basis that the provider represents a covered individual in a grievance filed under this chapter.

Sec. 19. (a) An insurer shall each year file with the commissioner a description of the grievance procedure of the insurer established under this chapter, including:

(1) the total number of grievances handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those grievances; and

(3) a summary of the final disposition of those grievances.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

Sec. 20. The department may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 14. IC 27-8-29 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 29. External Review of Grievances

Sec. 1. As used in this chapter, "accident and sickness insurance policy" has the meaning set forth in IC 27-8-28-1.

Sec. 2. As used in this chapter, "appeal" means the procedure described in IC 27-8-28-17.

Sec. 3. As used in this chapter, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

Sec. 4. As used in this chapter, "covered individual" has the meaning set forth in IC 27-8-28-3.

Sec. 5. As used in this chapter, "department" refers to the department of insurance.

Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a grievance filed under IC 27-8-28.

Sec. 7. As used in this chapter, "grievance" has the meaning set forth in IC 27-8-28-6.

Sec. 8. As used in this chapter, "grievance procedure" has the meaning set forth in IC 27-8-28-7.

Sec. 9. As used in this chapter, "health care provider" means a person:

(1) that provides physician services (as defined in IC 12-15-11-1(a); or

(2) who is licensed under IC 25-33.

Sec. 10. As used in this chapter, "insured" has the meaning set forth in IC 27-8-28-8.

Sec. 11. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-28-9.

Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

(1) an adverse determination of appropriateness;

(2) an adverse determination of medical necessity; or

(3) a determination that a proposed service is experimental or investigational;

made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's appeal resolution under IC 27-8-28-17 not more than forty-five (45) days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual may be required to pay not more than twenty-five dollars ($25) of the costs associated with the services of an independent review organization under this chapter. All additional costs must be paid by the insurer.

Sec. 14. (a) A covered individual who files an external grievance under this chapter:

(1) shall not be subject to retaliation for exercising the covered individual's right to an external grievance under this chapter;

(2) shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;

(3) shall be permitted to submit additional information relating to the proposed service throughout the review process; and

(4) shall cooperate with the independent review organization by:

(A) providing any requested medical information; or

(B) authorizing the release of necessary medical information.

(b) An insurer shall cooperate with an independent review organization selected under section 13(b) of this chapter by promptly providing any information requested by the independent review organization.

Sec. 15. (a) An independent review organization shall:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within seventy-two (72) hours

after the external grievance is filed; or

(2) for a standard appeal filed under section 13(a)(2)(B) of this chapter, within fifteen (15) business days after the appeal is filed;

make a determination to uphold or reverse the insurer's appeal resolution under IC 27-8-28-17 based on information gathered from the covered individual or the covered individual's designee, the insurer, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the independent review organization shall apply:

(1) standards of decision making that are based on objective clinical evidence; and

(2) the terms of the covered individual's accident and sickness insurance policy.

(c) The independent review organization shall notify the insurer and the covered individual of the determination made under this section:

(1) for an expedited external grievance filed under section 13(a)(2)(A) of this chapter, within twenty-four (24) hours after making the determination; and

(2) for a standard external grievance filed under section 13(a)(2)(B) of this chapter, within seventy-two (72) hours after making the determination.

Sec. 16. A determination made under section 15 of this chapter is binding on the insurer.

Sec. 17. (a) If, at any time during an external review performed under this chapter, the covered individual submits information to the insurer that is relevant to the insurer's resolution of the covered individual's appeal of a grievance decision under IC 27-8-28-17 and that was not considered by the insurer under IC 27-8-28:

(1) the insurer shall reconsider the resolution under IC 27-8-28-17; and

(2) the independent review organization shall cease the external review process until the reconsideration under subdivision (1) is completed.

(b) An insurer reconsidering the resolution of an appeal of a grievance decision due to the submission of information under subsection (a) shall reconsider the resolution under IC 27-8-28-17 based on the information and notify the covered individual of the

insurer's decision:

(1) within seventy-two (72) hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the covered individual's:

(A) life or health; or

(B) ability to reach and maintain maximum function; or

(2) within fifteen (15) days after the information is submitted, for a reconsideration not described in subdivision (1).

(c) If the decision reached under subsection (b) is adverse to the covered individual, the covered individual may request that the independent review organization resume the external review under this chapter.

Sec. 18. This chapter does not add to or otherwise change the terms of coverage included in a policy, certificate, or contract under which a covered individual receives health care benefits under IC 27-8.

Sec. 19. (a) The department shall establish and maintain a process for annual certification of independent review organizations.

(b) The department shall certify a number of independent review organizations determined by the department to be sufficient to fulfill the purposes of this chapter.

(c) An independent review organization must meet the following minimum requirements for certification by the department:

(1) Medical review professionals assigned by the independent review organization to perform external grievance reviews under this chapter:

(A) must be board certified in the specialty in which a covered individual's proposed service would be provided;

(B) must be knowledgeable about a proposed service through actual clinical experience;

(C) must hold an unlimited license to practice in a state of the United States; and

(D) must not have any history of disciplinary actions or sanctions, including:

(i) loss of staff privileges; or

(ii) restriction on participation;

taken or pending by any hospital, government, or regulatory body.

(2) The independent review organization must have a quality assurance mechanism to ensure:

(A) the timeliness and quality of reviews;

(B) the qualifications and independence of medical review professionals;

(C) the confidentiality of medical records and other review materials; and

(D) the satisfaction of covered individuals with the procedures utilized by the independent review organization, including the use of covered individual satisfaction surveys.

(3) The independent review organization must file with the department the following information on or before March 1 of each year:

(A) The number and percentage of determinations made in favor of covered individuals.

(B) The number and percentage of determinations made in favor of insurers.

(C) The average time to process a determination.

(D) Any other information required by the department.

The information required under this subdivision must be specified for each insurer for which the independent review organization performed reviews during the reporting year.

(4) Any additional requirements established by the department.

(d) The department may not certify an independent review organization that is one (1) of the following:

(1) A professional or trade association of health care providers or a subsidiary or an affiliate of a professional or trade association of health care providers.

(2) An insurer, a health maintenance organization, or a health plan association, or a subsidiary or an affiliate of an insurer, health maintenance organization, or health plan association.

(e) The department may suspend or revoke an independent review organization's certification if the department finds that the independent review organization is not in substantial compliance with the certification requirements under this section.

(f) The department shall make available to insurers a list of all certified independent review organizations.

(g) The department shall make the information provided to the department under subsection (c)(3) available to the public in a format that does not identify individual covered individuals.

Sec. 20. Except as provided in section 19(g) of this chapter, documents and other information created or received by the

independent review organization or the medical review professional in connection with an external grievance review under this chapter:

(1) are not public records;

(2) may not be disclosed under IC 5-14-3; and

(3) must be treated in accordance with confidentiality requirements of state and federal law.

Sec. 21. (a) An insurer shall each year file with the commissioner a description of the grievance procedure established by the insurer under this chapter, including:

(1) the total number of external grievances handled through the procedure during the preceding calendar year;

(2) a compilation of the causes underlying those grievances; and

(3) a summary of the final disposition of those grievances;

for each independent review organization used by the insurer during the reporting year.

(b) The information required by subsection (a) must be filed with the commissioner on or before March 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The commissioner may require any additional reports that are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

Sec. 22. (a) An independent review organization is immune from civil liability for actions taken in good faith in connection with an external review under this chapter.

(b) The work product or determination, or both, of an independent review organization under this chapter are admissible in a judicial or administrative proceeding. However, the work product or determination, or both, do not, without other supporting evidence, satisfy a party's burden of proof or persuasion concerning any material issue of fact or law.

Sec. 23. If a covered individual has the right to an external review of a grievance under Medicare, the covered individual may not request an external review of the same grievance under this chapter.

Sec. 24. The department may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 15. IC 27-13-2-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 3. (a) A foreign corporation, other than a foreign corporation defined under IC 27-1-2-3, may obtain a certificate of authority if the foreign corporation:

(1) is authorized to do business in Indiana under IC 23-1-49 or IC 23-17-26; and

(2) complies with this article.

(b) A foreign corporation (as defined in IC 27-1-2-3) may obtain a certificate of authority if the foreign corporation complies with this article.

(c) A foreign or alien health maintenance organization granted a certificate of authority under this section has the same but no greater rights and privileges than a domestic health maintenance organization.

SECTION 16. IC 27-13-2-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 6. (a) An applicant shall submit to the commissioner any modifications or amendments to the items of information required in an application under section 5 of this chapter.

(b) The commissioner may adopt rules under this section that provide that any modifications or amendments to the items of information in the application required of a health maintenance organization:

(1) must be submitted to the commissioner before the modification or amendment takes effect:

(A) for the approval of the commissioner; or

(B) for the information of the commissioner only; or

(2) must be indicated by the health maintenance organization to the commissioner at the time of the next succeeding site visit or examination of the organization by the department of insurance.

(c) A health maintenance organization shall file any assumed corporate name with the department at least thirty (30) days before assuming the name.

SECTION 17. IC 27-13-2-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 9. (a) A health maintenance organization established under this article may not:**

(1) use as a part of its corporate name the words "United States", "Federal", "government", "official", or any word that would imply that the company is an administrative agency of the state of Indiana or of the United States, or that

it is subject to supervision of any department other than the department of insurance; or

(2) take or assume a corporate name the same as, or confusingly similar to, an existing name of any other insurance company or other entity licensed or regulated under IC 27, unless at the same time:

(A) the other company changes its corporate name or withdraws from transacting business in Indiana; and

(B) the written consent of the other company, signed and verified under oath by its secretary, is filed with the department.

(b) This section does not affect the right of any health maintenance organization that:

(1) exists under the laws of Indiana as of July 1, 2001;

(2) exists under the laws of Indiana as of July 1, 2001, and thereafter reorganizes or reincorporates under this article; or

(3) is authorized to transact business in Indiana as of July 1, 2001;

to continue the use of its corporate name.

SECTION 18. IC 27-13-4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 1. (a) Subject to section 3 of this chapter, the powers of a health maintenance organization include the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of:

(A) hospitals and medical facilities;

(B) equipment for hospitals and medical facilities; and

(C) other property reasonably required for the principal office of the health maintenance organization or for purposes necessary in the transaction of the business of the organization.

(2) Engaging in transactions between affiliated entities, including loans and the transfer of responsibility under any or all contracts:

(A) between affiliates; or

(B) between the health maintenance organization and the parent organization of the health maintenance organization.

(3) The furnishing of health care services through:

(A) providers;

(B) provider associations; and

(C) agents for providers;

who are under contract with or are employed by the health maintenance organization. The contracts with providers, provider associations, or agents of providers may include fee for service,

cost plus, capitation, or other payment or risk-sharing arrangements.

(4) Contracting with any person for the performance on behalf of the health maintenance organization of certain functions, including:

(A) marketing;

(B) enrollment; and

(C) administration.

(5) Contracting with:

(A) an insurance company licensed in Indiana;

(B) an authorized reinsurer; or

(C) a hospital authorized to conduct business in Indiana;

for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.

(6) The offering of point-of-service products.

(7) The joint marketing of products with:

(A) an insurance company that is licensed in Indiana; or

(B) a hospital that is authorized to conduct business in Indiana;

if the company that is offering each product is clearly identified.

(8) Administration of the provision of health care services at the expense of a self-funded plan.

(b) A health maintenance organization may offer any of the following:

(1) Plans that include only basic health care services.

(2) Plans that include basic health care services and other health care services.

(3) Plans that include health care services other than basic health care services so long as at least one (1) of the plans offered by the health maintenance organization includes basic health care services.

(c) Notwithstanding subsection (a)(5), a health maintenance organization may not take credit for reinsurance unless the risk is ceded to a reinsurer qualified under IC 27-6-10.

SECTION 19. IC 27-13-4-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 3. (a) A **domestic** health maintenance organization must file notice with the commissioner, with supporting information that the commissioner deems adequate, before exercising any power granted in:

(1) section 1(a)(1); or

(2) section 1(a)(4);

of this chapter if the proposed transaction is equal to or greater than ten

percent (10%) of the health maintenance organization's admitted assets.

(b) A **domestic** health maintenance organization must file notice with the commissioner, with the supporting information that the commissioner deems adequate, before exercising any power granted in section 1(a)(2), if the proposed transaction is equal to or greater than three percent (3%) of the health maintenance organization's admitted assets.

(c) The commissioner may disapprove an exercise of power referred to in a notice received under subsection (a) or (b) only if, in the opinion of the commissioner, the exercise of the power would:

(1) substantially and adversely affect the financial soundness of the health maintenance organization; and

(2) endanger the ability of the health maintenance organization to meet its obligations.

(d) If the commissioner does not disapprove an exercise of power referred to in a notice received under subsection (a) or (b) within thirty (30) days after the notice is filed with the commissioner, the exercise of power is considered approved.

(e) The commissioner may adopt rules under IC 4-22-2 exempting from the filing requirement of this section certain activities that have a minimal effect on:

(1) the financial soundness of the health maintenance organization; and

(2) the ability of the health maintenance organization to meet its obligations.

SECTION 20. IC 27-13-8-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 1.5. (a) Each health maintenance organization authorized to conduct business in Indiana and required to file an annual statement with the department under this chapter shall prepare the health maintenance organization's statement:**

(1) on the National Association of Insurance Commissioners (NAIC) Annual Statement Blank;

(2) in accordance with NAIC Annual Statement Instructions; and

(3) following practices and procedures prescribed by the most recent NAIC Accounting Practices and Procedures Manual.

(b) To the extent that the NAIC Annual Statement Instructions require disclosure under subsection (a) of compensation paid to or on behalf of a health maintenance organization's officers, directors, or employees, the information may be filed with the department as

an exhibit separate from the annual statement blank. The compensation information described under this subsection shall be maintained by the department as confidential and may not be disclosed to the public under IC 5-14-3.

SECTION 21. IC 27-13-8-2, AS AMENDED BY P.L.133-1999, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 2. (a) In addition to the report required by section 1 of this chapter, a health maintenance organization shall each year file with the commissioner the following:

(1) Audited financial statements of the health maintenance organization for the preceding calendar year **prepared in conformity with statutory accounting practices prescribed or otherwise permitted by the department.**

(2) A list of participating providers who provide health care services to enrollees or subscribers of the health maintenance organization.

(3) A description of the grievance procedure of the health maintenance organization:

(A) established under IC 27-13-10, including:

(i) the total number of grievances handled through the procedure during the preceding calendar year;

(ii) a compilation of the causes underlying those grievances; and

(iii) a summary of the final disposition of those grievances; and

(B) established under IC 27-13-10.1, including:

(i) the total number of external grievances handled through the procedure during the preceding calendar year;

(ii) a compilation of the causes underlying those grievances; and

(iii) a summary of the final disposition of those grievances;

for each independent review organization used by the health maintenance organization during the reporting year.

(4) The percentage of providers credentialed by the health maintenance organization according to the most current standards or guidelines, if any, developed by the National Committee on Quality Assurance or a successor organization.

(5) The health maintenance organization's Health Plan Employer Data and Information Set (HEDIS) data.

(b) The information required by subsection (a)(2) through (a)(4) must be filed with the commissioner on or before March 1 of each year. The audited financial statements required by subsection (a)(1) must be

filed with the commissioner on or before June 1 of each year. The health maintenance organization's HEDIS data required by subsection (a)(5) must be filed with the commissioner on or before July 1 of each year. The commissioner shall:

(1) make the information required to be filed under this section available to the public; and

(2) prepare an annual compilation of the data required under subsection (a)(3) through (a)(5) that allows for comparative analysis.

(c) **Upon a determination by a health maintenance organization's auditor that the health maintenance organization:**

(1) does not meet the requirements of IC 27-13-12-3; or

(2) is in the condition described in IC 27-13-24-1(a)(5);

the health maintenance organization shall notify the commissioner within five (5) business days after the auditor's determination.

(d) The commissioner may require any additional reports as are necessary and appropriate for the commissioner to carry out the commissioner's duties under this article.

SECTION 22. IC 27-13-8-3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 3. (a) This section applies to a domestic health maintenance organization that is authorized to transact business in Indiana.**

(b) As used in this section, "NAIC" refers to the National Association of Insurance Commissioners.

(c) On or before March 1 of each year, a health maintenance organization shall file with the National Association of Insurance Commissioners and with the department a copy of the health maintenance organization's annual statement convention blank and additional filings prescribed by the commissioner for the preceding year. A health maintenance organization shall also file quarterly statements with the NAIC and with the department, on or before May 15, August 15, and November 15 of each year, in a form prescribed by the commissioner. The information filed with the NAIC under this subsection:

(1) must be:

(A) in the same format; and

(B) of the same scope;

as is required by the commissioner under section 1 of this chapter;

(2) to the extent required by the NAIC, must include the signed jurat page and the actuarial certification; and

(3) must be filed electronically in accordance with NAIC electronic filing specifications.

The commissioner may, for good cause shown, grant an exemption from the requirement of this section to domestic health maintenance organizations that operate only in Indiana. If a health maintenance organization files any amendment or addendum to the health maintenance organization's annual statement convention blank or quarterly statement with the commissioner, the health maintenance organization shall also file a copy of the amendment or addendum with the NAIC. Annual and quarterly financial statements are considered filed with the NAIC when delivered to the address designated by the NAIC for the filings, regardless of whether the filing is accompanied by any applicable fee.

(d) The commissioner may, for good cause shown, grant a health maintenance organization an extension of time for the filing required by subsection (c).

(e) In the absence of actual malice:

(1) members of the NAIC;

(2) duly authorized committees, subcommittees, and task forces of members of the NAIC;

(3) delegates of members of the NAIC;

(4) employees of the NAIC; and

(5) other persons responsible for collecting, reviewing, analyzing, and disseminating information developed from the filing of annual statement convention blanks under this section;

shall be considered to be acting as agents of the commissioner under the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of the collection, review, analysis, or dissemination of the data and information collected from the filings required by this section.

(f) The commissioner may suspend, revoke, or refuse to renew the certificate of authority of a health maintenance organization that fails to file the health maintenance organization's annual statement convention blank or quarterly statements with the NAIC or with the department within the time allowed by subsection (c) or (d).

SECTION 23. IC 27-13-8-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 4. (a) The commissioner may impose a civil penalty of five hundred dollars ($500), after notice and hearing under**

IC 4-21.5-3, on a health maintenance organization that fails to file an annual statement under this chapter.

(b) A domestic health maintenance organization that fails to file an audited annual financial statement under section 2(a)(1) of this chapter before June 1 of each year without obtaining an extension is subject to a civil penalty of fifty dollars ($50) per day until the report is received by the commissioner.

SECTION 24. IC 27-13-13-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 9. (a) As used in this section, "noncovered health care expenditures" means the costs to a health maintenance organization for health care services:**

(1) that are the obligation of the health maintenance organization;

(2) for which the enrollee may be liable in the event of the health maintenance organization's insolvency; and

(3) for which:

(A) no alternative arrangements have been made that are acceptable to the commissioner; or

(B) statutory deposits and net worth of the health maintenance organization are determined by the commissioner to be inadequate.

(b) If noncovered health care expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall deposit cash or securities that are acceptable to the commissioner with:

(1) the commissioner; or

(2) an organization or trustee approved by the commissioner through which a custodial or controlled account is maintained.

(c) The deposit made under subsection (b) must have a fair market value:

(1) calculated on the first day of each month; and

(2) maintained for the remainder of the month;

of not less than one hundred twenty percent (120%) of the health maintenance organization's outstanding liability for noncovered health care expenditures for enrollees in Indiana, including incurred but not reported claims.

(d) The commissioner may require a health maintenance organization to file periodic reports, including reports on liability for noncovered health care expenditures and audit opinions, that the commissioner considers necessary to monitor compliance with

this section.

SECTION 25. IC 27-13-15-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 2. If:

(1) the contract between a health maintenance organization and a participating provider has not been reduced to writing as required by this chapter; or

(2) the contract fails to contain the provision required by section ~~1(2)~~ **1(a)(4)** of this chapter;

the participating provider may not collect or attempt to collect from the subscriber or enrollee any sums that are owed by the health maintenance organization.

SECTION 26. IC 27-13-15-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 3. **(a)** A:

(1) participating provider; or

(2) trustee, an agent, a representative, or an assignee of a participating provider;

may not **bring or** maintain any legal action against a subscriber or an enrollee of a health maintenance organization to collect sums owed by the health maintenance organization.

(b) Except as provided in subsection (c), if a participating provider of a health maintenance organization brings or maintains a legal action against a subscriber or enrollee for an amount owed to the participating provider by the health maintenance organization, the participating provider is liable to the subscriber or enrollee for costs and attorney's fees incurred by the subscriber or enrollee in defending the legal action.

(c) A participating provider shall not be liable to the subscriber or enrollee for costs and attorney's fees described in subsection (b) if the participating provider can demonstrate a reasonable basis for believing at the time the legal action was brought and while the legal action was maintained that the health maintenance organization did not owe the sums the participating provider sought to collect from the subscriber or enrollee.

SECTION 27. IC 27-13-18-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 1. (a) In the event of receivership of a health maintenance organization, the commissioner may order all other carriers that participated in the enrollment process of the group covered by the organization in receivership at the last regular enrollment period of the group to offer the enrollees of the organization in receivership an enrollment period of thirty (30) days beginning on the date of receivership.

(b) Each carrier referred to in subsection (a) shall offer the enrollees

of the health maintenance organization in receivership:

(1) the same coverage;

(2) under the same terms; and

(3) at the same rates;

as the carrier had offered at the last regular enrollment period of the group. The coverage required under this chapter shall begin on the date of receivership and end on the date the contract period would have ended had the health maintenance organization not gone into receivership.

(c) If there is no carrier referred to in subsection (a), or the commissioner determines that there is no carrier referred to in subsection (a) that has adequate or accessible resources, the commissioner shall equitably allocate the:

(1) group contracts of the health maintenance organization in receivership; and

(2) individual contracts of the health maintenance organization in receivership belonging to enrollees who are unable to obtain other coverage;

among all health maintenance organizations operating within a portion of the service area of the health maintenance organization in receivership. The commissioner shall not allocate individual contracts to a health maintenance organization that does not offer direct individual enrollment.

(d) A health maintenance organization to which the commissioner allocates a group contract under subsection (c)(1) shall offer to the group existing coverage that is most similar to the group's coverage with the health maintenance organization in receivership, at rates consistent with the successor health maintenance organization's existing rating methodology.

(e) A health maintenance organization to which the commissioner allocates individual contracts under subsection (c)(2) shall offer to the enrollee existing individual or conversion coverage that is most similar to the enrollee's coverage with the health maintenance organization in receivership, at rates consistent with the successor health maintenance organization's existing rating methodology.

SECTION 28. IC 27-13-22-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 1. **(a)** A licensed insurer or a hospital authorized to conduct business in Indiana may, ~~either directly or~~ through a subsidiary or an affiliate, organize and operate a health maintenance organization under this article.

(b) This section does not apply to a health maintenance

organization granted a certificate of authority under this article before July 1, 2001.

SECTION 29. IC 27-13-23-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 8. A health maintenance organization shall file a copy of any examination report filed by the insurance commissioner of another state during the preceding calendar year with the annual statement required under IC 27-13-8-1.**

SECTION 30. IC 27-13-32-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 1. (a) This section does not apply to a health maintenance organization or a limited service health maintenance organization that is a foreign corporation. ~~or is owned by a foreign corporation.~~

(b) As used in this section, "foreign corporation" means a corporation organized or reorganized under the law of a state or jurisdiction other than Indiana.

(c) A person may not acquire control, as that term is defined in IC 27-1-23-1, of a health maintenance organization or a limited service health maintenance organization unless:

(1) that person complies with the requirements of IC 27-1-23-2; and

(2) the acquisition is approved by the commissioner under the procedure set forth in IC 27-1-23-2.

SECTION 31. IC 27-13-32.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 32.5. Voluntary Dissolution

Sec. 1. Upon authorization of voluntary dissolution by the board of directors and any shareholders entitled to vote in respect of the voluntary dissolution, the board of directors shall:

(1) cause a notice that the health maintenance organization is about to be dissolved to be published at least once in a newspaper of general circulation, printed and published in the English language, in the county in which the principal office of the health maintenance organization is located, and at least once in a newspaper of general circulation, printed and published in the English language in the city of Indianapolis, Marion County, Indiana;

(2) cause a copy of the publication under subdivision (1) to be mailed to each subscriber;

(3) file a copy of the publication under subdivision (1) with the

department;

(4) file a certified copy of the articles of dissolution with the department; and

(5) present to the department the certificate of authority issued or renewed under IC 27-13-3-1 for cancellation.

The department shall file the certified copy of the articles of dissolution, cancel the certificate of authority, endorse the cancellation on the certificate, and return the canceled certificate of authority to the health maintenance organization or its representatives.

Sec. 2. The dissolution of a health maintenance organization under this chapter does not alter the rights of an enrollee under IC 27-13-7-13.

SECTION 32. IC 27-13-34-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 7. (a) After December 31, 1994, a person, corporation, partnership, limited liability company, or other entity may not operate a limited service health maintenance organization in Indiana without obtaining and maintaining a certificate of authority from the commissioner under this chapter.

(b) A for-profit or nonprofit corporation organized under the laws of another state, other than a foreign corporation defined under IC 27-1-2-3, may obtain a certificate of authority to operate a limited service health maintenance organization in Indiana if the foreign corporation is authorized to do business in Indiana under IC 23-1-49 or IC 23-17-26 and complies with this chapter.

(c) A foreign corporation (as defined in IC 27-1-2-3) may obtain a certificate of authority to operate a limited service health maintenance organization in Indiana if the foreign corporation complies with this chapter.

(d) A foreign or alien limited service health maintenance organization granted a certificate of authority under this chapter has the same but not greater rights and privileges than a domestic limited service health maintenance organization.

SECTION 33. IC 34-30-2-114.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 114.5. IC 27-7-12-9 (Concerning communications regarding termination of a homeowner's insurance policy).**

SECTION 34. IC 34-30-2-116.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 116.7. IC 27-8-29-22 (Concerning independent review organizations).**

SECTION 35. IC 34-30-2-119.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 119.3. IC 27-13-8-3 (Concerning data and information collected from health maintenance organization filings).**

SECTION 36. [EFFECTIVE JULY 1, 2001] **(a) Notwithstanding IC 27-8-28-19 and IC 27-8-29-21, both as added by this act, the information required under IC 27-8-28-19 and IC 27-8-29-21, both as added by this act, must be filed beginning March 1, 2003.**

(b) This SECTION expires June 30, 2005.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, Corporations and Small Business, to which was referred House Bill 1555, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 4, line 35, after "has" insert "**knowingly**".

Page 14, line 34, after "(4)" insert "**upon request of the named insured,**".

Page 15, line 15, after "(4)" insert "**upon request of the named insured,**".

Page 15, line 33, after "renewed" insert "**only**".

Page 15, line 35, delete "until" and insert "**unless**".

Page 15, line 37, delete "until" and insert "**unless**".

and when so amended that said bill do pass.

(Reference is to HB 1555 as introduced.)

CROOKS, Chair

Committee Vote: yeas 12, nays 0.